JOHN R. SEELEY

*The Future of Psychiatry**

My main function . . . must be to initiate a conversation among us.

ROBERT J. OPPENHEIMER

I do not seek, in this paper, to present a finished, fully articulated argument, girded about with even momentary moral certainty. I merely suggest some openings towards views, some first tentative gropings and movements of thought and feeling. I cannot even guarantee that any part of what I say is news.

For reasons which may be evident later, I should like to take pains to clarify my role and the status of my statement. I come among psychiatrists as a "friendly stranger"—which is also, I take it, the position from which they speak to their patients. The role of the stranger, as Georg Simmel has so well described it, is that of the person who is simultaneously near and far, who accordingly sees some things and misses some, and sees yet others in a perspective different from our own. I need hardly press my claim to the title: I am no biologist, no physician, and my concerns are chiefly with society and social theory rather than with men in their severalty and practice with its problems. Nor must I press my claim too far: not to the point of utter strangeness. I have lived among psychiatrists for twenty years now, either as a guest in their scientific house or as host to them in mine.

I have qualified the word "stranger" by the word "friendly" for good reason. By the use of that word I imply the existence between us of a disinterested love—a congeniality, tempered and enlivened, fed and restrained, by what I believe to be our dedication to a common obligation. If I urge anything upon you, it is only in virtue, as Polyani would say, of a commitment to ends which are sufficiently universal to command and unite us both. Is this not also the relation within which and the ethic under which your practice is conducted? Is it not true, as I heard someone

*A lecture given on the twenty-fifth anniversary of the Psychiatry Service at Massachusetts General Hospital.

say recently, that we have the right to seek to change only what we love? Is it not also true that we may say we love only what we are willing to take responsibility for changing?

Last, let me warn in preface, that what is in form a prediction is in fact a plea. In stating a belief as to the future of psychiatry, I am in fact seeking to give effect to a hope. I am making an assertion which tends to tip the balance of action in favour of its own confirmation. A psychiatrist who tells his patient, explicitly or implicitly, that he expects him to recover, is counting upon what appears as a statement of fact to have a consequence in what it purports to predict. So am I. We hold up mirrors, but the reflections from them inescapably and sometimes profoundly alter the objects reflected. Therapy counts upon the fact and social science must come to terms with it.

The practice of psychiatry is, I am sure, full of satisfaction—win, lose, or draw with the patient. There is joy in success; heightened interest and determination in the face of failure. It is only when we try to make what we do intelligible that the difficulties multiply and, for good reason, the anxiety mounts. This difficulty is common to all professions. All have secrets: some to be concealed from the public, some from colleagues, some even from oneself, the *ultra-privatissima*. But psychiatrists who believe in uncovering when covering hampers performance may be under special mandate to steel themselves to its pains. In any case, since I also believe that the future of psychiatry is bound up so much more with clarification of theory than inventions of practice, I shall assume that the pressures of necessity are added to the fortitude and patience for which I ask.

Foremost among the insufficiently aired or examined questions in psychiatry is the one concerning its relation to other medical specialties. It has fought so long and hard for a place in the medical sun, for recognition as a respectable specialty, that it has emphasized its similarities almost to the point of denying difference. Yet it differs from the others more deeply than they differ from each other, and that distinction is of the essence, not the accidents, of psychiatry. Other specialties differ from each other by distinctions in space—the human geography seized upon, GU, GI, ENT, and so on—or distinctions in time such as paediatrics or gerontology. What psychiatry deals with essentially has no locus in space and no focus in time. It differs in the most radical of all possible ways, since it treats of and with man as human, a being in a moral order, as over against the natural order, biological or physical.

Psychiatrists in their role as general physicians may *in that role* deal with their patients as machines or organisms, that is, as objects. But to the degree that they do so, they are either merely (as general physicians) creating suitable conditions for their true work as psychiatrists, or using mechanical or biological means to communicate a human message. Such a conjuncture of roles or mixture of means may be practically inescapable, but practical convenience should not be allowed to obscure theoretical clarity. That which is essentially psychiatric in the compound act is that in which a person is dealt with as a person by a person, that which lies wholly in the dimension of the distinctively human, that which is altogether in the order of choice and value.

For this reason, because of the order of reality addressed, psychiatrists are inevitably allied with and fraternal to all others who deal with man as man: priest, king, philosopher, teacher, preacher, pundit, and propagandist. The psychiatrist alone, in this sense, represents humanity in the court of medicine; and only in the sense in which medicine, in general and regardless of means, is itself an organization of tender, loving care does he represent medicine in the court of humanity. The psychiatrist is thus cast in the role of ambassador in two countries of a third country yet to be defined. He may expect the privileges of embassy—some diplomatic immunity, a chance to be heard on occasion—but he must not be surprised to be regarded as "strange," to be only partly understood, to have such views as are understood taken account of rather than adopted. Even these privileges may only accrue when the identification is clear; an undeclared ambassador may seem something less to others as well as to himself.

Once the distinction is clear, the chances of peace, order, and good government in medicine are vastly increased. We might, moreover, have a less divided performance, a more vivid self-image for ourselves, psychiatrists, and social scientists alike. There might even ensue a cessation of attempts to state perfectly valid human insights in pseudo-physical, pseudo-biological terms—a procedure that robs them of their immediate power of conviction without establishing them securely in the forum of science.

It follows, I think, that theory *in* psychiatry is social theory, and theory *about* psychiatry is philosophy. Physics and biology bear on another and circumambient realm. The practice of psychiatry is hence social practice, and physical and biological practice come in as mere *mise-en-scène*, mere condition-creation for psychiatry itself.

It is difficult to overstress the point. Might I be permitted an analogy from education, which also has the perennial difficulty of disentangling from the myriad things that educators do those acts or aspects of acts that can rightly be called "education." One condition for effective teaching usually is that the child can see a classroom's length to the blackboard. If he is unable to see so that the teacher can teach, the eye problem may be mechanical and amenable to surgery or correction by spectacles; or it may be physiological and tractable by vitamins or other ingestanda. But surgery-doing and pill-giving are not education, even if (which God forbid) the teacher does them; they merely establish conditions favourable to the pursuit of it. Even should the teacher argue (as all might and some do) that first-aid given by him shows love and hence establishes a relation inside which education can proceed better or deeper, surely this does not mean that the administration of first-aid *is* education. It means, at most, that a teacher should or must sometimes perform *other* roles for the sake of his distinctive and unique one. Whether he separates or mixes roles in practice is a matter of practical convenience and must be judged by practical tests; whether he distinguishes his roles theoretically is a matter of vital moment. If he isn't clear, at least in his thinking, he confuses himself and others. And confusion is precisely that which an educator—like a psychiatrist—is mandated to dispel.

You may wish to maintain that physical, biological, and social interventions are so closely linked in the equivalence of their effects that I have overdrawn a distinction to make a point. A little improvement in surgery or pharmacology might soon make it possible by a surgical nick here or there, a tablet or capsule now and then, to banish anxiety, allay the consciousness of guilt, evoke euphoria, release energy, engineer mood, and so on. (I am told that a little alcohol will, even now, do these things for some.) What then becomes of a distinct moral order? Is psychology not reducible to physics and chemistry?

I think not. I agree that we could remove from the universe all generically psychiatric problems. One way would be to exterminate all people. If that seems a trifle radical, a competent corps of anaesthesiologists together with a team of specialists in intravenous feeding could, no doubt, remove from the world all psychiatric problems—except their own. But, obviously, such interventions remove psychiatric problems in precise proportion as they destroy human nature. Less radical interventions simply alter the base from which psychiatry has to operate. Like other forms of increase in affluence, or available possibilities, such means

augment rather than diminish the problems with which psychiatry has to deal. As long as humanity remains, irreducibly psychiatric problems remain: they have to do with what man can do with himself as a human being, not as a machine or an animal. The better he is cared for as machine and animal, the more open his human potentialities, the greater his psychological vulnerability, probably the more numerous and the greater his psychiatric problems.

So much for the relation to medicine.

The distinction drawn does something more, however, than redefine the relation of psychiatry to medicine. The fact that psychiatry deals with men as members of a moral order alters every important perspective we have upon it. It raises new epistemological problems: problems of the kind of knowledge we can have of such a being in that capacity. It raises new conceptual problems: questions about the meanings to be attributed to key terms such as "health" and "disease." It raises ethical questions, having to do with the criteria for success, the warrant for interventions of various extents, and so on. It raises linguistic questions: What is a vocabulary appropriate to catch what we want to talk about?

Let me begin with some assertions in a philosophy of knowledge—not, be it noted, a psychology of knowledge. There is a difference between the consequences of a mistaken conception of its "object" in physics and a mistaken conception in psychology or social science. A mistaken idea in physics leads to inconvenience for the scientist, but does not affect the behaviour of physical objects. A mistaken idea in psychology, *per contra*, is not only inconvenient to the knower; it limits or traumatizes both the knower and the known, and is thus not only scientifically but morally a wrong. In "taking a view" of man, and of the relation of human science to man, we have to confront simultaneously scientific and moral criteria of rightness: a right view is a good view, and a wrong view is not simply erroneous but bad.

I shall maintain that the right view—the view justified by the facts—and the good view as to the object of a science of man are one and the same. I shall also maintain that the sciences of man share one object or purpose, equally centrally, with the practice of psychiatry. The object is nothing more nor less than to liberate or free man, to increase the range, significance, and importance of his choice.

How is such a view to be reconciled with the prevailing view that the object of any science is the discovery of determinate connections? Obviously, if this definition of science is insisted upon, it would be better

to renounce the use of the word "science" than to twist our perception of what is the meaning of "human" and "social." The difference may cut deep enough to call for another term, and some of the reasons are obvious.

In physics, the statement of law that relates volume, temperature, and pressure neither frees nor binds the action of molecules. But, of course, the molecules do not hear us, and we, the speakers, are not molecules. When we state "a law of human nature," even if correctly, human beings do hear us, and we are human beings. The very statement of the law alters the nature of what we are speaking about, and virtually invites, or sometimes directly effects, an escape from the determinacy that it is supposed to establish or describe. Let me illustrate. A really naïve and tradition-bound culture has as its culture-bearers persons whose lives are indeed to a sensible degree "determined by their culture." If prediction is the aim of science, we can probably very well predict about them. If determinacy is the test, we have determinacy. But along comes an anthropologist and states as a law that human beings are tradition and culture bound. Eventually his "subjects" hear him or read him. Knowledge of what he has said is now "in the culture" so that if his people are "culture bound," they are now bound by a radically different culture. Moreover, they, having this knowledge, are by that much radically different. So that what is bound as well as what binds is changed. Once a "tradition-bound" culture has, as an element in it, the knowledge that it is tradition-bound, the society concerned is well on the way to the probability or necessity of self-regulation by some other mechanism. Tradition, in virtue of knowledge as to its effective control, is in movement toward the loss of effective control.

The social scientist has thus a most peculiar role. When he speaks, as a human or social scientist, he is standing in one sense outside and above the system he is talking about. But if he credits his own performance, he must, as Polyani also maintains, credit the capacity of others to do the same. We must therefore accredit also the capacity of others to alter or negate the very regularity that we reported upon. What we do then, in making our assertions about human behaviour, is to shape steps upon which men may eternally climb out of the very pits in which we observe them.

I am thus asserting what I believe to be a fundamental metaphysical statement: that when we talk of man or men we are speaking of utterly indeterminate, absolutely infinite systems—at least as far as the long-run future is concerned. When we talk of atoms, we may with reasonable

confidence hold that the laws of gravitation will be the same in a million years as now. When we talk of man, we cannot even predict to 1984; or, if we do, we may ensure by so doing either that it turns out as Orwell sketched it, or that precisely that fate is avoided.

A human system is thus one in which any statement about the system is vitally *in* the system, immediately or in the next virtual instant. Such a system has indeed a history, but cannot have scientific laws analogical to those of chemistry and physics. It is not merely that the system is open or has feedback. The very statement of a determinacy or determinate relation feeds back not into a mechanical and deterministic process, but into a creative, building-up act, the living of a life, which the asserted determinacy really must deny as its premise. You cannot say to a child something as simple even as "If you hit your little brother you'll feel ashamed" without *in the statement* altering him, you, and the probability of the stated association of events.

This view implies another (a statement about human nature thus implying another about the nature of human knowledge of matters human). Clearly, the human knower stands outside the human known, whether the known is another or himself. Even if, in the same instant or the next, he takes cognizance of himself as knower and himself as known, it is now a new knower, now outside the first knower and the first known. And so infinitely. Human knowledge thus appears as a flickering snapshot of a movement that in the next instant falsifies its own picture. Knowledge of things human is thus journalistic, that is, more or less true but only for its instant, rather than timeless, as in physics or chemistry. These observations are not merely, I think, about matters of fact in metaphysics and epistemology. Do they not point also to the very views that you would wish the patient to have of himself? Would you not regard the seizing of them in their full implication as among the criteria of practical success in therapy? Surely it is an aim of therapy to reduce the role of determinacy, to open and free the patient for choice. And a necessary condition, if not a sufficient one, for such reduction is that the patient should come to some such belief, or faith rather, in himself. Is this not part of what you wish, yourselves, to communicate?

There is another curious aspect about the facts in which we deal. It was implicit in my remark on the place of faith in therapy. Patently, facts emerge from the infinite flux of reality *as facts*, only in virtue of our interests. What may have been true with reference to falling apples from before time was becomes a "fact" only when someone implicated directly

or vicariously in a line of action needs to establish what the facts are to permit the activity to go on or build up.

The most important human facts, as Polyani says, only appear in passionate conviction and commitment, which, of course, lies beyond mere interest. Much more: the facts are *constituted* by the passionate commitment. This is not quite Berkeley's problem of the tree in the quad, but very near to it and much more credible. A love-object does not exist except in virtue of our love toward it. As a hunk of matter or an animal or even a person it may exist independently; but as a love-object it is whole and entire the creature of our passion. Similarly, justice exists and is real, so far and only so far as men are devoted and dedicated to it. It, too, is literally the creature of their passion, as, I suggest, is everything we care for or ought to care for. As we give our passion rein, we people a Universe that is otherwise empty of objects worthy of our interest.

Inquiry into human affairs, or reporting about them, cannot therefore be "objective" or "detached" or unimpassioned if it is not to miss the very things we set forth to seek. Inquiry can be "disinterested," but that is very different. May I claim again that these views, if true, are not merely philosophical assertions, but crucial and decisive communicanda in therapy. Faith is neither mere knowledge nor belief, but belief wedded to passion: belief of a kind capable of self-confirmation, wedded to passion sufficient to tip the balance toward confirmation. And faith is surely the tendril on which life winds to light; failing faith, life fails of its vitality.

This brings me to another connected point, central to psychiatric practice, and distinguishing psychiatry again from all other medical specialties. Psychiatry is the only specialty in medicine in which the theory of the subject is itself the remedy or a substantial part of the remedy. It is as though the surgeon were to cut open the patient with his theories and suture him with his hypotheses. The surgeon doesn't; you do. Inescapably, your patient gets better or worse, by coping with your view of himself, of man, of society, of reality, of what is "appropriate" and "inappropriate." Your theories and commitments, taken as a unity, are the cast and splints within which and upon which, if at all, psychic limbs are sufficiently straightened to permit natural or better-than-natural growth to be resumed. Indeed, transcending the analogy, the cast may become bone of the patient's bone. So your theory about man and your moral position are not just "basic" to psychiatry; they are "in" and "are" psychiatry. This truth also is, I trust, a communicandum of therapy.

I suppose I cannot continue without touching upon the matter of health and disease, since it is concern with these that distinguishes you among the other "caretakers," as Erich Lindemann has happily called them. Even in the biological order, the terms are hard enough to define. In the moral order the difficulty is even greater. In biology we usually have readily available, well-founded criteria of normative performance for the biological class of which our specimen is a sample. By a disease we mean any long-standing process that grossly militates against such performance—if the process is economically remediable. (If it is not economically remediable, we call it a defect.) Veterinarians are thus able to act with relative certainty and uncomplicatedness. Even a paediatrician dealing, *qua* biologist, with an age-sex-height-weight problem in a child has relatively little difficulty. When we as men seek to deal with men as men a host of problems arise. Every previous criterion loses its simplicity.

In reference to the moral order we can define a normative process, but we cannot see its end because nothing is visible except as we are in it, and the end retires and enlarges like an expanding horizon as we advance. The normative process is one of socialization, followed or accompanied by trans-socialization. The pre-socialized, potential person, brought into a set of relationships with actual living, loving persons, is caught up in a meaningful role in a presently ongoing complex of social acts, and is introduced to and made at home in a culture. This is stage one. Some never get so far. Some do in a fashion, but fall back or fall out. Some go farther, and this is stage two. This is the stage or process in which one's relations to particular and living persons are transcended: not thus devalued but given increased value and meaning. This is the stage in which the role assigned is transformed and transfigured by reference to a view of the universe, and hence not simply accepted as assigned by "society." Neither Riesman's gyroscope of superego nor radar of peer-group reference largely guides action. The culture is transcended, ceases to be the placenta of psychological life, and becomes a domain for aesthetic or ethical or other value-giving operation. The result is not merely transcendence of but change and enrichment of the culture, without limit. This view at least leads away from the moral dilemmas and ambiguities of operation of an adjustment psychiatry—a fit servant only of a totalitarian state.

But if this is the normative process (the process of being caught up into an actual and also an ideal society), surely not everything that falls short of it is to be labelled disease or defect, at least in the sense that it

falls into the psychiatrist's particular sphere of concern or area of operation. How we are to draw a working definition of "disease," from such a statement of the ideal, requires that we turn for a moment to consider the relation of ideals to action.

A number of obvious things may be said at once. The want of a clear ideal is one way to self-destruction. The wrong relation to or conception of the role of the ideal is another. Unguided action is self-defeating. Action directed merely to momentary melioration is unsatisfying. What an ideal should do is to define a structure and establish an order with reference to what exists and what does not yet exist. Action directed toward achievement of an ideal all at once—or indeed toward everything it implies, indifferently and in any order—implies at worst paralysis and at best diminution of attainable goods. Hence counsels of perfection are counsels of despair.

We must therefore unquestionably do first things first. We must seek to remove present, blatant, manifest, remediable evils before we seek to bring into being remoter potential goods. We may *say* with W.H.O. that we are dedicated to health as a positive, ideal state rather than a mere non-negative condition. We may cherish and be cherished by such a vision. But it is to be noted that under that mandate they have gone off to deal first and energetically with yaws, TB, malaria, and malnutrition.

One additional reason for orderly advance in the field of mental health is the very dynamic character of the norm, already alluded to. It seems obvious, but it needs saying, that every gain in "mental health" opens to greater clarity the psychic eye that may see and define what ideal "mental health" is. The norm thus moves, enlarges, and in a sense becomes more distant as we move toward it. This view both implies and assumes what I mean to imply and assume: an infinite moral space which is man's natural and inescapable home. The problem is how to live in it, duly awed but not so overawed as to lose the capacity for present expansion into it. A clear image of what is involved is not so much (or not only) a matter of progress in thinking about it as of progress in the achievement of it.

What are the most blatant remediable evils, I must leave to you to determine. (It is not obvious that mental illness, so-called, is the number one enemy in your field.) But that you must order your enemies, and adjust your strategy and logistics to that order, I do not doubt. I am only made uneasy by statements that indicate it is time to shift our attention from disease cure, palliation, mitigation, or prevention to the realm of

"positive mental health." Only a part of my concern stems from the lack of clarity attaching to the notion.

There is a deeper difficulty lurking in such ideas, one pointed to in the realm of politics long ago by Karl Popper in *The Open Society and Its Enemies*. He makes out, I believe, an altogether convincing case. He maintains that when the State seeks to go beyond the task of removing or preventing present blatant evils on to the establishment of the good life for its citizenry, their freedom and the openness of the society fall first victims to the attempt. Since this freedom and openness is to me a more general good than any good the State might seek, the State's claims to eminent domain everywhere, even if beneficent, cannot be countenanced. What is true for the super-parental figure, the State, is, I think, true in the everyday life of everyday parents, and for you who operate in between. We are gardeners not sculptors, in the figure of Homer Lane, one of your illustrious predecessors. We uproot weeds, we loosen soil, we remove obstacles to growth; we do not push and pull the living substance into neater shapes.

I believe, then, that while you are obligated to remember, to be guided by, to be passionately committed to maximum, open, wholly ideal norms of health—and to make that passionate dedication visible—you are warranted in interference, especially autogenous or unsolicited interference, only to remedy or avert or mitigate gross and obvious evil. This remark may not be nearly as trivial as it sounds. I have heard at least one planner in recent months lay claim to the role of trustee for a new and not very clear utopia. I have heard more than one psychiatrist assert the same. I have heard at least one proposal for merging the two roles. And I am not unfrightened as I hear echoes in these dreams of the moral foundations that every would-be autocrat is forced to lay down for his legitimation.

This brings me to an attempt to restate the criterion for psychiatric success. I asked one of the great men in your field, this summer, how he knew when he had succeeded with a boy. In a language typical for him, he answered cryptically and profoundly "Vulnerability, I suppose." What he meant became clear as the conversation proceeded. A boy who was "better" was a more voluntarily "open" boy, a boy not frozen or carapaced in rigid defenses, a boy who could and would be willing to be wounded again for the sake, presumably, of a good greater than mere security. I am drawn to that view.

But what *is* that greater good for which we have a right to ask that a man should be willing to be wounded? Perhaps it is the same good that,

in another sense, is said to render him invulnerable. It must not only be a reward-in-prospect sufficient to make vulnerability tolerable, but a reward-in-retrospect that makes any and every further advance in this direction possible. What is that good? It has many names, but an anthropologist's term will serve. We may call it "kinship." The opposite of kinship is "alienation," and when psychiatrists were called "alienists" (even if for another reason) the core of their mission might have been more clearly implicit in their title. As you know, you as psychiatrists are first (and often, sole) kin to the most alien; you are also the means whereby these are transformed with diminishing alienation into a kinship, greater without limit.

The notion of kinship excludes the necessity or transcends the limits of adjustment and "fitting in." Kinship not only permits and tolerates otherwise intolerable differences, it values them because it refers all differences not just to the two-point "interpersonal relation" involved, but to a third point, the family, which orders the other two in the realm of value. The appropriate third point of reference for patient and psychiatrist is never necessarily or ever exclusively the existent family, society, or social order. Indeed, these function, in the realm of value, as instances and embodiments merely of that moral order and that wider fellowship to which they point—the dead, the living, those who may yet live, and those who can only be imagined in the quickened heart. It is alienation from *that* fellowship and order that is, I hazard, not merely the cause, but the criterion, of the sickness psychiatrists seek to combat. And the criterion for their success is not that where id reigns ego shall be, but that where alienation ruled kinship shall triumph.

It will be obviously implicit to many of you that no man can effectively recall another into such kinship in virtue of mere knowledge about it. We cannot call others into a kinship not our own. I said earlier that right knowledge is in psychiatry your essential tool. I am now saying that what you *are* is equally essential. This is so not only because what you are is a measure of your capacity to use what you know. It is true because in matters human what we know and what we are are not separable and different. The illusion that they can be is one master-illusion with which psychiatry deals. The future of psychiatry is thus inseparable from the one process by which psychiatrists and those they affect grow without limit into knowledge quickened by passion, and passion given form by knowledge.